

**DISCLOSURE OF HIV STATUS TO SEXUAL PARTNERS BY
PEOPLE LIVING WITH HIV**

by

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DECLARATION

I declare that **DISCLOSURE OF HIV STATUS TO SEXUAL PARTNERS BY PEOPLE LIVING WITH HIV** is my own work and that all the sources that I have used or quoted have been indicated and acknowledged by means of complete references.


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ABSTRACT

This study explored factors associated with the reluctance of people living with HIV (PLWH) to disclose their (Human Immunodeficiency Virus (HIV) statuses to their sexual partners at Galeshewe Day Hospital in Kimberley in the Northern Cape.

The study was an in-depth interview based qualitative research; and purposive sampling technique was utilised to select 13 PLWH aged between 18 and 45.

Among males, factors contributing to the reluctance of disclosure to sexual partners are ignorance, fear of rejection, not knowing where to start when disclosing and secrecy.

Despite the complexity of disclosure, all participants understood the importance of disclosing to sexual partners as this will prevent new infections.

There is a need for HIV prevention strategies to focus on males particularly, to strengthen disclosure counselling services provided to PLWH and to advocate strongly for partner testing.

Key terms:

Disclosure; sexual partnership; HIV status; sero-discordance.

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List of abbreviations

ASSSA	Antenatal Sentinel HIV and Syphilis prevalence Survey Annual
Aids	Acquired Immune Deficiency Syndrome
ARV	Antiretroviral
CDC	Centre for Disease Control
GHS	General household survey
HIV	Human Immunodeficiency Virus
PLWH	People living with HIV
SAFE	Sero-status to fighting epidemic
SAIRR	South African Institutes of Race Relation
SES	Socio-economic status
SP	Sexual partners
UNAIDS	United Nations Programme on HIV/AIDS
UNISA	University of South Africa
USA	United State of America
USAID	United State Agency for International Development
WHO	World Health Organization

List of annexures

Annexure A	Requesting permission from Chief Executive Officer to conduct the study
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Annexure D	Guiding interview schedule
Annexure E	Ethical clearance certificate

CHAPTER 1

INTRODUCTION AND BACKGROUND INFORMATION

1.1 INTRODUCTION

The study is about disclosure of HIV (Human Immunodeficiency Virus) status among people living with HIV (PLWH) and those with Aids (Acquired Immune Deficiency Syndrome) to their sexual partners. Disclosure has significant health implications, firstly because the negative outcomes of disclosure can be detrimental and severe for those affected, and secondly because low rates of disclosure may increase cases of HIV transmission to others (UNAIDS 2006:10-11). In South Africa, new infections are reported every day despite the interventions and efforts put in place to fight the pandemic. Given this trend, strategies to increase disclosure may be a way of reducing new infections.

Louque (2010:28) states that HIV infections continue to spread each year. New infections may suggest that infected people have sex with those who were not previously infected and they become infected. Ignorance of the sexual partner status has also been shown as the main reason for the spread of HIV.

While disclosure can be an important strategy for controlling the spread of HIV, because of the protective benefits to individuals and the health system, there are challenges that inhibit voluntary disclosure (Maman, Mbawambo, Hogan, Kilonzo & Sweat 2001:373-382; Odunsi 2007:295-306), and these require measures to help PLWH and those with Aids deal with them (Adedimaji 2010:17).

1.2 RESEARCH PROBLEM

Available literature shows that there is less disclosure of one's HIV status to a sexual partner (Almeleh 2004:139; Gari, Habte & Markos 2010:12). Partners who are HIV-positive usually disclose to other family members such as parents and siblings but rarely to sexual partners (Horn 2010:1; Harris & Touray 2004:12). The researcher at her

work area of Galeshewe Day Hospital's wellness clinic also noticed that patients, especially women who tested HIV-positive were reluctant to share their diagnosis with their sexual partners, preferring to tell their parents or siblings.

In 2008, the Northern Cape had fewer prevalence rate compared to other provinces in South Africa (Antenatal Sentinel HIV and Syphilis prevalence Survey Annual (ASSSA) 2003, 2008). However, in a study by Isaac and Hara (2008:8) on mainstreaming of HIV and Aids into South African Fisheries Policy showed that the population studied in the Northern Cape were not aware of the underlying factors that contributes to HIV and Aids (Isaac & Hara 2008:8). One of these factors may be the reluctance to disclose one's HIV status to sexual partners. The study therefore purports to explore factors associated with PLWH to disclose their HIV status to their sexual partners.

1.3 PURPOSE OF THE STUDY

The purpose of the study is to explore factors associated with the PLWH to disclose their HIV statuses to their sexual partners.

1.4 OBJECTIVES OF THE STUDY

The objectives of the study are to

- investigate participants' views about HIV status disclosure to sexual partners at Wellness Clinic at Galeshewe Day Hospital at Kimberley in the Northern Cape
- identify factors that influence disclosure of HIV-positive status to sexual partners

1.5 RESEARCH QUESTIONS

The grand tour questions for this study were: "Tell me your thoughts on disclosing your HIV status to your sex partner", followed by other questions such as: "Would you share your thoughts on what factors make PLWH disclose or not disclose to their sexual partners?"

1.6 SIGNIFICANCE OF THE STUDY

It was empirical to carry the study to know more about disclosure to sexual partners for PLWH as this would assist in improving planning for HIV interventions among PLWH at Galeshewe Day Hospital's Wellness Clinic. Disclosure of HIV status offers considerable benefits from both an individual and public health perspective (WHO 2003). If measures are put in place to increase disclosure among PLWH to sexual partners, this might contribute to reducing the rate of new infections because when boyfriends/girlfriends, husbands and wives know about the status of their partners, they will take measures to protect themselves at all times and this could contribute to low mortality rate, prolong life expectations and productive active participation in daily life knowing that significant other people know about one's HIV status.

The importance of disclosure can never be overemphasised. It reduces the burden of guilt and secrecy. It encourages healthy attitudes as partners come to understand and approach safer practises, such as abstinence, sticking to one sexual partner, using protection, and so forth. It prolongs the life of the infected and affected as all above work in synergy to prolong their lives and promote their relevance and productive participation in daily activities, in their families and society (Adedimaji 2010:16).

Testing and notification of significant others such as parents, peers and boyfriends/girlfriends at risk are among strategies aimed at preventing new infections and slowing the transmission of HIV in general population (Adedimaji 2010:16).

Issues of discrimination and stigma have been previously cited as possible factors that may hinder disclosure to sexual partners (Thupayagale-Tshweneagae 2010:260, 2011). However, there are more benefits to be gained in disclosing than not disclosing (Thupayagale-Tshweneagae & Benedict 2011:6).

1.7 ETHICAL CONSIDERATIONS

The ethical protection of respondents was maintained throughout this study. Before the study began, ethical clearance was obtained from Research and Ethics Committee of the Department of Health Studies at the University of South Africa (UNISA) (Annexure

A). Institutional consent was obtained from Galeshewe Day Hospital Wellness Clinic after communicating through a formal letter from UNISA (Annexure B).

1.8 RESEARCH METHODOLOGY

1.8.1 Research design

Qualitative design was used in this study because it aimed to explore, describe and explain persons' experiences, behaviours, interactions and social context without use of statistical procedure (Fossey 2002:717). The current study explored and explained behaviours of PLWH on disclosure to their sexual partners.

1.8.2 Setting

The study setting was Galeshewe Day Hospital Wellness Clinic at Kimberley, in the Northern Cape Province of South Africa. The clinic attends to PLWH every Wednesday for support and counselling.

1.8.3 Population and sample

The research population in this study consisted of male and female PLWH aged between 18 and 49 years.

1.9 OPERATIONAL DEFINITIONS USED IN THE STUDY

Aids: is an epidemiological definition based on signs and symptoms. It is caused by HIV, the immunodeficiency virus (UNAIDS 2011:4).

Counselling: According to UNAIDS (2011:6), terminology it is an interpersonal, dynamic communication process between a client and a trained counsellor, who is bound by code of ethics and practise, to resolve personal, social, or psychological problems and difficulties.

Disclosure: When one partner shares his or her HIV status with another partner (or any other person), this is referred to as disclosure. Individuals learn their HIV test results

alone; they often bear the burden of disclosing their HIV status to their partners without assistance from a trained counsellor or healthcare provider (WHO 2012:9).

HIV: Which weakens the immune system, ultimately leads to Aids (UNAIDS 2011:12).

HIV status: The absence or presence of antibodies for HIV antigen. Positive means exposure to HIV, negative means no detectable exposure to HIV (CDC 2005).

Partner: Somebody who is involved in an activity with somebody else (Encarta Dictionary: English 2012). In this study, a partner refers to two people who have sex together e.g. husband and wife, boyfriend and girlfriend.

Sero-discordance: Is when one partner is HIV-positive and the other is negative. Although one partner is currently HIV negative, this does not mean that this partner is “immunised” or protected against getting HIV in the future. It is of paramount importance for sero-discordant couples to avoid transmission to the HIV negative partner. It is possible for couples to stay sero-discordant indefinitely if they consistently practise safer sex using male and female condoms. It is said the annual risk of transmission of HIV from an uninfected partner in sero-discordant couples can be reduced from 20-25% to 3-7% in programmes where condom use is recommended for prevention (WHO 2012:8).

Sexual partner: Two persons in an on-going sexual relationship: each of these persons is referred to as “partner” in the relationship (WHO 2012:7).

1.10 ORGANISATION OF THE DISSERTATION

The dissertation is divided in the following chapters:

Chapter 1: Introduction and background information

Chapter 2: Literature review

Chapter 3: Research methods and design

Chapter 4: Findings and literature control

Chapter 5: Discussion of findings

Chapter 6: Conclusions, limitations and recommendations

1.11 CONCLUSION

Chapter 1 presented the introduction on the study, the purpose, significant and setting of the study. It has defined the terms used throughout the study and outlined the layout of the following chapters.

CHAPTER 2

LITERATURE REVIEW

2.1 INTRODUCTION

The chapter will present an overview of literature relevant to the study on disclosure of HIV status to sex partners. The journals were identified through scholar goggle search. The terms used during the computer-based searches included disclosure among PLWH, and HIV disclosure to sex partners.

The articles varied in terms of sample size, study design and methods of data collection. The studies also targeted a wide variety of populations including men, women and men having sex with men.

The outline of the chapter will be as follows:

- The importance of disclosure
- Reported rate of disclosure in the reviewed studies
- Factors motivating disclosure
- Barriers to disclosure
- Consequences of disclosure
- Conclusion

2.2 THE IMPORTANCE OF DISCLOSURE

Disclosure by PLWH and those with Aids is critical for HIV prevention and care (Seid, Wasie & Admassu 2012:97). However, HIV-positive persons face significant challenges to disclosing their HIV status, and failure to disclose can place their sex partners at risk (Kebede, Woldemichael, Wonderfrash, Haile & Amberbir 2008:81). Disclosures of HIV status contribute to general wellbeing of PLWH and those with Aids. The WHO (2004:4) in their study on gender dimensions reported that disclosure can lead to increased HIV

preventive behaviours. The WHO (1997) and the Centers for Disease Control and Prevention (CDC 2002:50:1-5) in their protocols for HIV testing and counselling emphasise disclosure as an important public health goal for a number of different reasons including prevention of the spread of HIV.

There are a number of important benefits to the infected individual and to the general public. First, disclosure may motivate sexual partners to seek testing, change behaviour, and ultimately decrease transmission of HIV. In addition, disclosure may facilitate other health behaviours that may improve the management of HIV. It has now been recognised, however, that there are a number of barriers that HIV-infected individuals face when sharing their test results with friends, family and, most importantly, sexual partners (Kebede et al 2008:81).

There is considerable interest in finding strategies to encourage disclosure because of the public health benefits that may accrue from the disclosure of HIV status. Disclosure of HIV test results to sexual partners is associated with less anxiety and increased social support among women (Kebede et al 2008:81).

HIV status disclosure may lead to improved access to HIV prevention and treatment programmes, increased opportunities for risk reduction and increased opportunities to plan for the future. Disclosure of HIV status also expands the awareness of HIV risk to untested partners, which can lead to greater uptake of voluntary HIV testing and counselling and changes in HIV risk behaviours. It is clear from the literature that risk behaviours change most dramatically among couples where both partners are aware of their HIV sero-status (Seid et al 2012:103).

In addition, disclosure of HIV status to sexual partners enables couples to make informed reproductive health choices that may ultimately lower the number of unintended pregnancies among HIV-positive women (Anglewicz 2008:18).

2.3 RATE OF DISCLOSURE AMONG PEOPLE LIVING WITH HIV

A review done by gender dimensions indicates that studies conducted in developing countries showed low disclosure compared to developed countries (WHO 2004:5). The WHO (2004:5) report indicated that the rate of disclosure to sexual partners are higher

among women in the developed world (average 71%; range: 42%-100%) compared to women in the developing world (average 52%; range: 16%-86%). WHO (2004:5) states that there is a core group of people who choose not to disclose HIV test results to anyone (3-10% in the (United States of America (USA) and 10%-78% in developing countries). This indicates that more studies need to be done in the developing countries to assist with disclosure.

Disclosure rates to sexual partners increase over time. Bulletin World (2004:299) in their studies have found rates of disclosure which ranged from 16.7% to 86% of women who choose not to disclose their HIV status to their sex partners, with women attending free-standing voluntary HIV testing and counselling clinics more likely to disclose their HIV status to their sexual partners than women who were tested in the context of their antenatal care.

According to Niccolai, King, D'Entremont and Pritchett (2006:103), overall rates of disclosure vary between studies, but many studies indicate that disclosure does not occur in a substantial minority of sex partnerships, perhaps 20% to 50%. A growing body of research suggests that disclosure is more common to primary sex partners than to non-primary sexual partners and to HIV-infected partners than to HIV-negative or unknown sero-status partners. Some, but not all, studies show a relationship between disclosure and unprotected intercourse (Sullivan, Voss & Li 2010:508).

Simbayi, Kalichman, Strebel, Cloete, Henda and Mqeketo (2007:29-34) reported that 42% out of 85% sexually active participants had sex with a person to whom they had not disclosed their HIV status in the previous three months and they were more likely to have multiple partners. This can impact on the HIV new infections.

This study was in congruence with Kalichman and Nachimson (1999:281-287) in his study which showed that 41% of his participants had not disclosed their HIV sero-status to sex partners. Men who had not disclosed to partners indicated lower rates of condom use during anal intercourse and scored significantly lower on a measure of self-efficacy for condom use compared to individuals who had disclosed and this is also indicated by HIV-positive people falling pregnant unintended with a chance of infecting their partners.

Similarly, Sullivan (2009a:412) reported that there is an association between disclosure and condom use for men but not for women.

Wang, Shan, Chan, Chen, Ge, Ding, Zhang, Duan, Liu, Liu, Yang, Chen, Chen and Wan (2010:685-690) found that the proportion of those who disclosed positive sero-status results to their sexual partners was 90.2%. This indicates that with continual encouragement of disclosure and acceptance of the HIV-positive sero-status, we can make a great difference.

This study also identified a relatively larger difference between the proportion of disclosure to regular partners and the proportion of disclosure to casual partners (94.8% versus 13.0%) in comparison with other studies.

Sullivan and Voss (2010:205) in their study of female disclosure of HIV-positive sero-status indicated a 75,2% disclosure rate and 59.9% of condom use among females, which indicate use of condoms among female than in their 2009 study. This is an improvement. An analysis of the data done by Sullivan (2005:33-47) suggests that differences in disclosure rates vary based on sex partner factors including sero-status, relationship status and number of sex partners. In his study rates of disclosure to primary sex partners ranged from 67% to 88%, suggesting that nearly one third of main sex partners were not disclosed to and were at risk of contracting HIV, whereas a pattern of lower disclosure among casual partners was evident. As the number of sex partners increased, the likelihood of disclosure to all sex partners decreased, ranging from one quarter (25%) to slightly over half (58%).

Generally, from the reviewed most studies reported high rate of disclosure. Only one study, conducted in 1999, reported a low rate below 50%. This shows there more studies and more interventions the more disclosure will improve over years.

2.4 FACTORS MOTIVATING DISCLOSURE

Sullivan (2009a:412-456) says that perceived self-efficacy and positive outcome expectations were the most frequent theoretical constructs embedded in the research associated with disclosure, suggesting that these factors play an important role in the

process of disclosure to sex partners. The WHO (2004:18) found that there are cultural factors that influence the patterns of self-disclosure to sexual partners and other social network members. These included a sense of ethical responsibility, failing health, social support, minimising stress associated with non-disclosure, and disclosure. Sullivan (2005:33-47) reported that interpersonal factors that positively influenced self-disclosure included spousal support, emotional investment, and communication about safe sex, including asking about a partner's sero-status. Self-disclosure was not consistently associated with safer sex.

2.5 BARRIERS TO DISCLOSURE

More studies done on disclosure of HIV status to sex partners have shown that there is some form of disclosure to sex partners but not all PLWH are willing to disclose, depending on their circumstances. Findings by review paper on gender dimension indicated that the most common barriers to disclosure included fear of abandonment, fear of rejection/discrimination, fear of violence, and fear of upsetting family members, which does not differ with other recent studies (WHO 2004:12).

Bulletin World (2004:300) in their study cited barriers in women to include fear of accusations of infidelity, abandonment, discrimination and violence. Between 3.5% and 14.6% of women reported experiencing a violent reaction from a partner following disclosure. Women's fear of abandonment was closely tied to fear of loss of economic support from a partner. Fear of losing the instrumental support from partners is found to be a major consideration when deciding whether to share HIV status or not.

Kalichman and Nachimson (1999:281-287) indicated that having not disclosed to sex partners was closely associated with lower self-efficacy for disclosing, with women who had not disclosed reporting the lowest disclosure self-efficacy. As PLWH are encouraged to disclose their HIV status, interventions are needed to facilitate disclosure (Kalichman & Nachimson 1999:282).

Sullivan (2005:33-47) asserts that discussing sexual partner's sero-status was associated with non-disclosure for both men and women. Additional factors influencing disclosure for men included cocaine and marijuana use, and years since diagnosis. Being transgendered was associated with less disclosure. Adedimaji (2010:20) in his

study highlighted a range of systemic, cultural, gender and personal issues that regulate HIV and Aids disclosure in a context of socio-cultural and demographic transformation.

2.6 CONSEQUENCES OF DISCLOSURE AND STIGMA

Studies by Anglewicz (2008:18), Kebede et al (2008:81) and Seid et al 2012:103) indicate that since HIV and Aids frequently carry stigma, talking about being HIV-positive is not an easy task, especially to sex partners. With more people being tested (and counselled), knowledge of the disease increase and, hopefully, this contribute towards a reduction in external stigma. However, internal stigma also prevents self-acceptance and disclosure (Adedimaji 2010:20; Kadowa & Nuwaha 2009:26-33; Kebede et al 2008:81).

Reviewed studies show that stigma still persist as a barrier to disclosure. Reducing HIV and Aids stigma is a lengthy process. In the meantime, disclosure needs to be considered carefully (Saloner 2005:33). Simbayi et al (2007:29-34) allege that HIV-related stigma and discrimination are associated with not disclosing HIV status to sex partners, and non-disclosure is closely associated with HIV transmission risk behaviour. Disclosure may have destructive or even life-threatening consequences for some individuals, for example, violence may result from a partner, family member or community as reported in findings of the review studies. Positive consequences are also being reported by the studies and they outweigh negative consequences.

Non-disclosure may also have significant negative consequences. Living secretly with HIV can involve living with guilt, shame and self-hatred as indicated by Saloner (2005:33), which will have adverse impact on the rate of new HIV infections.

Kalichman and Nachimson (1999:281-287), in his study, cited emotional distress among persons who had not recently disclosed. This can impact on coping with their illness, which can result in faster progression of the disease. Hence, one can see that the person living with HIV and Aids needs to carefully weigh up the potential negative and positive consequences of both disclosure and non-disclosure.

In some cases the decision about whether or not to disclose does not concern only the welfare of the HIV-positive individual. For instance, the decision not to disclose to a

sexual partner places the partner at some risk of infection. WHO asks whether or not a disclosure is a “beneficial disclosure”. Beneficial disclosure includes disclosure to a sexual partner and confidential discussion about an HIV-positive client among healthcare workers for the benefit of the client. Beneficial disclosure respects the autonomy and dignity of the client while also aiming to prevent the onward transmission of HIV (Saloner 2005:33-35).

A gender dimension study has found positive outcomes of HIV status disclosure to sexual partners to be common. This results in increased support, acceptance and kindness, decreased anxiety and strengthened relationships (WHO 2004:16). Similar outcomes, which included safer sexual practices through condom use, were identified by Masupe (2011:55) in her study.

While fear of negative outcomes is a major barrier to HIV status disclosure, the actual rate of reported negative outcomes affected a relatively small proportion of those who disclosed in gender dimension study. Negative outcomes reported included blame, abandonment, anger, violence, stigma and depression. Similar reactions were reported by Gillett and Parr (2010:337-344) in their study at Kenya.

Literature from sub-Saharan Africa also cites fear of blame, violence and abandonment by a partner, as well as stigma and isolation within the home and community as major barriers to status disclosure by HIV-positive women (Maman et al 2001; Medley, Garcia-Moreno, McGill & Maman 2004; Greeff, Phetlhu, Makoe, Dlamini, Holzemer, Naidoo, Kohi, Uys & Chirwa (2008:311). Feelings of defeat, disappointment, emotional trauma, sadness and relief were among those reported by participants in the study done by Masupe (2011:55) et al in Botswana.

The reports of violence following disclosure were more common in studies conducted in the developing world. Women who reported violence as a result of disclosure in the USA study tended to be low socio-economic status women of colour with a history of violence in their relationships.

Gender dimensions further reported that HIV-infected women with a sero-discordant sexual partner may be at increased risk for violence following disclosure. A Bulletin World (2004:302) study also found the majority of women who disclosed HIV test results

to their partners reporting supportive reactions from partners. Negative outcomes were less common and included shock, disbelief, abandonment and violence.

Fear of negative outcomes was nonetheless the barrier to HIV status disclosure most often mentioned by women. There are a number of potential risks from disclosure for HIV-infected women, including loss of economic support, blame, abandonment, physical and emotional abuse, discrimination and disruption of family relationships, according to bulletin World. These risks may lead women to choose not to share their HIV test results with their friends, family and sexual partners. This, in turn, leads to lost opportunities for the prevention of new infections and for the ability of these women to access appropriate treatment, care and support services where they are available. An important finding is that disclosure was not associated with the break-up of marriages.

In fact, four of the studies reported that most marriages survived disclosure. Some, but not all, studies show a relationship between disclosure and unprotected intercourse. Despite conflicting evidence, it is generally thought that disclosure decreases the likelihood of unprotected intercourse with uninfected partners as a result of a sense of responsibility to protect partners, although some individuals may knowingly choose to engage in calculated risks (Niccolai et al 2006:103).

Niccolai et al (2006:103) further stated that at the very least, disclosure of sero-status to partners promotes communication about safer sex and allows individuals to make informed choices about their behaviours. These issues are critical in light of the centres for Disease Control and Prevention Sero-status Approach to Fighting the Epidemic. If people with HIV and Aids act on knowledge of their sero-status by adopting and sustaining HIV, risk reduction behaviours, that may include disclosing their status to sex partners – transmission of HIV could be reduced.

2.7 CONCLUSION

According to findings of literature review, interventions are needed in South Africa to reduce the Aids stigma and discrimination and to assist people with HIV to make effective decisions on disclosure.

CHAPTER 3

RESEARCH METHODS AND DESIGN

3.1 INTRODUCTION

This chapter explains the setting where the study was conducted, population study, sampling techniques and data collection methods including ethical considerations undertaken during the research.

3.2 RESEARCH METHODS

This section will cover the research strategy, design, context, population, sampling and data gathering and analysis.

3.2.1 Research strategy

Botman, Greeff, Mulaudzi and Wright (2010:189) argue that research strategy is sometimes referred to as strategies of inquiry, research approaches or methodology. Research strategy describes the skills, assumptions and material practices researchers use when they move from a paradigm and a research design to the collection of empirical materials (Botman et al 2010:189).

The research strategy for the study was phenomenology. Polit and Beck (2008:227) describe phenomenology as an approach to exploring and understanding people's everyday life experiences. Phenomenology accepts that each person is unique and has their own life experiences (Polit & Beck 2008:227). The strategy was applicable to this study as it explored the factors associated with reluctance of PLWH to disclose their HIV status to their sexual partners.

3.2.2 Research design

According to Polit and Beck (2008:66), research design is an overall plan that helps a researcher obtain answers to the research questions and helps the researcher address challenges that may arise while conducting the research. The study was conducted in a form of exploratory qualitative approach. Qualitative design was appropriate for this study because it allowed the researcher to study the sample's life experiences and social environment, and make predictions based on the data.

In addition, it is also appropriate because the phenomenon under study is deeply rooted in the participants personal knowledge or understanding of themselves and is of delicate and sensitive nature, thus making the participants vulnerable.

A qualitative method allowed the researcher to understand how the participants perceived their situation and their role within the disclosure context. Due to the subjectivity of the qualitative design the researcher was able to incorporate the participants' perceptions and ideas into the research findings. The participants' perception of themselves and their environment influences their behaviour (Joubert & Ehrlich 2007:318). Therefore, by understanding the participants' perceptions and social factors, we are more likely to predict their health-related behaviours (Joubert & Ehrlich 2007:318).

Qualitative research aims to answer why certain behaviours occur or why people have certain views. It is often the only methodology used when the aim is to get an in-depth sense of what people think of a particular object or event. The in-depth interaction between the researcher and the participants make this approach appropriate when used as a process to establish some form of action or campaign and intervention based research (Joubert & Ehrlich 2007:318).

3.2.3 Research context

Botman et al (2010:195) said: "Qualitative studies are always contextual, as the data are only valid in a specific context and not meant for generalisation of findings as in quantitative generalising research". This study was contextual. The context was a

wellness clinic at Galeshewe Day Hospital at Kimberley, Northern Cape, South Africa. The clinic attends to PLWH every Wednesday.

3.2.4 Population

Brink (2006:123) defines population as the entire group of persons or objects that is of interest to the researcher, in other words, that meet the criteria which the researcher is interested in studying. The target population was made of participants living with HIV and Aids attending wellness clinic at Galeshewe Day Hospital and met the following criteria:

- PLWA male and females aged between 18 and 49 years at Galeshewe Day Hospital's wellness clinic in the Northern Cape. This age group have been selected because according to Avert (2010:47), almost one in three women aged between 25 and 29 years are affected and over a quarter of men aged 30 and 34 years are affected in Sub-Saharan Africa. Generally the population most affected globally is between the ages of 15 and 49 years (UNAIDS 2010:29). The age group was chosen on the basis of age of consent in South Africa.

3.2.5 Sampling method

Purposive sampling was utilised while recruiting the participants. This form of sampling allows for selection of key or typical individuals from the spectrum in which we are interested (Joubert & Ehrlich 2007:101). The aim was to obtain a sample that represents all important sub-groups of the population and hopes to cover the diversity of the target group as well as what is typical in this way.

Purposive sampling was applicable to this study as the researcher selected specific readily available patients who met the criteria to participate. The sample size consisted of 20 women and men aged between 21 and 45 years old. All the participants in the sample group had access to the ARV services at Galeshewe Day Hospital. The number of participants in a qualitative study is adequate when the saturation of information is achieved in a study. The sample size totalled 13 (n=13). Saturation was achieved after 11 interviews. Saturation of data occurs when no additional sampling provides any new information (Polit & Beck 2008:71).

3.2.6 Data gathering

In-depth interviews were used to collect information in this study. In-depth interviews allow the participants to communicate their priorities and give detailed responses on the issues raised. According to Joubert and Ehrlich (2007:319), an in-depth interview is probably the most used form of qualitative data collection that is used to elicit behaviours of individual participants. It generally takes the form of a discussion between interviewer and interviewee on the research topic. The researcher was the primary data collection instrument guided by list of questions. Using semi-structured interview as a data gathering method allowed the researcher to clarify questions and to probe further to obtain information.

3.2.6.1 Data collection process

Data was collected from the 6 August to 31 August 2012. Community counsellors at the clinic assisted with recruitment of participants following the eligible criteria. The researcher then contacted the participants telephonically to make appointments with them. Out of the 16 recruited participants, one declined, one did not answer her phone and the other had left the area by the time of contact. Each participant was seen on separate dates depending on their availability. The researcher explained the contents of the consent form to each participant before the actual interview (Annexure C).

The researcher entered the field with a list of questions to be covered in the interview (Annexure D). The questions were used to guide the researcher. A list of questions consisted of participant's demographic details, which covered participants' marital status, level of education and employment status. Other areas covered were the participants' knowledge of their partners' HIV status, their views on the importance of disclosing and what they thought could be done to assist with disclosure. The list of the questions did not inhibit the researcher from discussing unforeseen issues that were not planned for during the course of the interview.

The interviews were conducted in Setswana because the participants were most familiar and comfortable with the language. Although the consent form was in English the researcher clearly explained it in Setswana. Participants were individually

interviewed at the identified private room at the hospital. The interviews lasted between 10 to 45 minutes and varied from participant to participant. Interviews were tape recorded with the permission of the participants and field notes were also made during the interview.

As discussed above the discussions were directed by the list of questions so that the required information can be obtained, but respondents were allowed to talk and cover the area in their own terms and from their own perspective. This method is generally used when detailed information is needed from individuals. The major advantage is that it gives the respondent an opportunity for personal explanation and a detailed response (Joubert & Ehrlich 2007:26). The individual focus allows the interviewer to draw out the information in more detail while the respondent is talking and thinking about the subject (Joubert & Ehrlich 2007:26). The researcher transcribed all the interviews verbatim.

3.2.7 Data analysis

Data from each component of the study was analysed using Joubert's (2007:238) principles of content analysis. According to Joubert (2007:324), the general term used for analytic process in qualitative research is content analysis, which starts by exploring in detail common themes and then establishing them into units of meaning and codes. Data analysis followed the following steps:

- The researcher began data analysis with a search for broader categories or themes. Polit and Beck (2008:515), which involves the discovery not only of commonalities across subject but also of natural variation and patterns in the data.

Next step involved validation of thematic analysis

- Some researchers use quasi statistics, which involves a tabulation of the frequency with which certain themes or relations are supported by data. The researcher used tabulation and frequencies.
- Final step, the researcher weaved the thematic strands together into an integrated picture of phenomena under investigation.

3.3 TRUSTWORTHINESS

Trustworthiness was established according to the strategies promoted by Lincoln and Guba (1985:11). The measures undertaken to establish trustworthiness were credibility, dependability and transferability.

3.3.1 Credibility

Polit and Beck (2004:751) define credibility as “a criterion for evaluating integrity and quality in qualitative studies”. The researcher ensured credibility by describing participant’s experiences accurately as emphasised by Holloway (2005:8). Credibility was ensured through member checking.

3.3.2 Member checking

Member checking is a technique used by the researchers to improve the accuracy, credibility and validity of the study (Polit, Beck & Hungler 2001:433). Member checking provides the researcher with the opportunity to correct errors and challenge wrong interpretations. It also gives the research participants an opportunity to volunteer new information. In this study, the researcher regularly read out to the participants what she had written to validate the recorded information.

3.3.3 Dependability

The dependability of qualitative data refers to the stability of data over time and over conditions (Polit et al 2001:363). In order to achieve dependability for this study, the researcher developed an audit trial. The findings were made open to scrutiny by the supervisor (Polit et al 2001:362).

3.3.4 Transferability

Transferability refers to the ability to generalise the data: the extent to which the findings from data can be transferred to other settings or groups (Polit et al 2001: 362; Streubert

Speziale & Carpenter 2003:39). In this study the researcher used a nominated sample and dense descriptions to ensure transferability.

3.4 ETHICAL CONSIDERATION

In this study, the researcher adhered to the following principles of ethical conduct:

3.4.1 Permission

Ethical clearance was obtained from the UNISA's Department of Health and Higher Degrees Committee before the research could commence (Annexure E). Management at Galeshewe Day Hospital gave permission for the researcher to conduct the study at the hospital (Annexure B).

3.4.2 Consent form

The right of the participants was protected by stating the research objectives and obtaining their consent. Request of consent from participants informing them about the purpose of the investigation and as well as the possible risks and benefits of the study was also done before each interview (Annexure C).

3.4.3 Principle of beneficence

To adhere to this principle, according to Brink (2006:32), the researcher needs to secure the wellbeing of the subject, who has the right to protection from discomfort and harm be it physical, emotional, spiritual, economic, social or legal. In this study, the researcher ensured that participants were comfortable and were interviewed in a private room away from noise and prying eyes.

3.4.4 Right to privacy, confidentiality and anonymity

According to Brink (2006:32), the right to privacy is the individual's right to decide to whom and to what extent to reveal his or her attitudes, beliefs and behaviour. Privacy was maintained through utilising private room for the interviews.

Confidentiality refers to agreements between persons that limit the access of others to private information. Participants were reassured that the information they provided would not be shared with anyone else and where possible the offer of later feedback would be made. Anonymity means that the participant's identity must be kept secret and the readers should not be able to identify the participants who took part in the research (Botman et al 2010:17). The researcher adhered to the principle by referring to the research participants by pseudonyms instead of using their real names. All tape recorders and transcripts will be destroyed upon completion of the study.

Privacy was ensured by interviewing participants in a private room at the wellness clinic. The researcher and the person interviewed were the only ones in the interviewing room per session to ensure that what was said was known only to the researcher and the individual participant. Participants' were assured that information collected would be kept in the strictest confidence, which was done through anonymity and use of pseudonyms.

3.4.5 Refusal and withdrawal from the study

The participants were informed that they had the right to refuse to participate in the study and that they could withdraw from it at any time during the course of the study. Furthermore, the researcher informed them that they would be treated with respect and not be penalised in any way should they decide to leave.

3.5 CONCLUSION

The chapter elaborated on the setting where the study was conducted, population study, sampling techniques and data collection methods as well as ethical considerations undertaken during the research.

CHAPTER 4

FINDINGS AND LITERATURE CONTROL

4.1 INTRODUCTION

This chapter presents the realisation of pilot testing, data gathering data analysis as well as a discussion of findings of the study.

4.2 PILOT TESTING, DATA GATHERING AND ANALYSIS

Pilot testing data gathering, analysis and the sample are described.

4.2.1 Pilot testing

Two participants were used to pilot the questions that guided the study (Annexure D). From the pilot study it became apparent that 45 minutes duration will be adequate.

4.2.2 Data gathering

Interviews were conducted on approval of the High Degrees Committee of the Department of Health Studies at the University of South Africa (Annexure E) as well as the management of Galeshwe Day Hospital (Annexure B). Data was collected from the 6 August to 31 August 2012. The researcher verified the information with the participants at the end of each interview.

4.2.3 Data analysis

Thematic analysis of data was used following Joubert's principles. The researcher began data analysis by first searching for broader categories or themes. The researcher used tabulation and frequencies to present the data and finally broader themes were weaved together into thematic strands to give an integrated picture of the phenomenon under investigation.

4.2.4 Sample description

The participants were selected according to the criteria specified in Section 3.2.5. A brief description of each of the participants will be given and pseudonyms are used for the purposes of confidentiality and anonymity.

Kitso is a 42-year-old unemployed woman and a single parent to two children. She learned about her HIV-positive status in 2000. When she noticed that her partner looked sick and was constantly coughing, she decided to test for HIV. Her partner passed away in 2003. She got involved with another partner in 2003 and they had been together for four years at the time of data collection.

She informed him about her status. He accepted and did not reject her. Kitso said that her partner would sometimes bribe her for not using a condom. He refused to take an HIV test and when she encouraged him to get tested he always claimed to have done it at a private doctor but never revealed his status. The day after Kitso revealed her HIV status to her partner he insisted to have unprotected sex with her. This surprised Kitso.

Kitso was worried because her partner began to look sick. She said it helps to disclose your HIV status to your partner because keeping it a secret can destroy the relationship. She encourages PLWH to join support groups that will help them become more accepting of their status as this will help them in facilitating disclosure to their partners.

Ole is a 39-year-old unemployed single man. He learned about his status in 1997 when he became sick. He is currently single because the mother of his child deserted him when he got sick. They did not have a chance to discuss his HIV status but Ole noticed that the mother of his child got involved with different men after she left.

He tried to pursue relationships with other women once he recovered but they did not show any interest in him. Although he tries to pursue relationships with people with the same status, he has lost hope in relationships. Ole is willing to disclose his status to his partner when he finds one. He says that it is important to disclose your status to your partner so that you can protect her from getting infected. He encouraged counsellors to communicate disclosure with patients in detail in order to facilitate the process.

Gontse, who is unemployed, is a 31-year-old single mother to one child. She learned about her status in 2006. She was involved in a relationship with her partner for eight years. When he found out about her status, he broke off the relationship. During their relationship her partner claimed to have tested negative but did not want to use a condom. Gontse wondered why he did not want to use a condom although he said he was negative and Gontse was positive.

After the break up Gontse decided to date other people and although she disclosed her HIV status to them, they would not take her seriously and still insisted on having unprotected sex. She broke off the relationships and refused to have unprotected sex with anyone. She says it is difficult to disclose your HIV status to your sex partner because one does not know where to start. She stated that there are several benefits of disclosing your status to your partner such as the reduction of new infections. She said government should encourage others to disclose their status and recommend partner testing to ease the problem.

Kagiso (28) is employed and has three children. His four-year-old child passed away in February 2011. The child was born in 2008 and tested negative. Kagiso had been cohabiting with his partner for seven years at the time of data collection. He learned about his status in 2000 but did not take it seriously because he did not feel or look sick. On several occasions, after the HIV-positive results, he went for more tests and tested negative. Kagiso did not inform his partner about his status and he did not use condoms. He rather used traditional medicines.

In 2006 he went for another test with his partner and they both tested negative. In 2010, Kagiso got a job and began to drink a lot. He became sick. When he went to the doctor an HIV test was administered to him and he tested positive again. He informed his partner about his status and she accused him of infidelity. His partner then became pregnant with another man's child during the period of his illness.

Kagiso was no longer in a relationship by the time of data collection. He feels that disclosing your HIV status only scare partners away. He says that at one particular time, one partner got really angry with him after he'd disclosed. He aims to continue dating but says that he will not disclose his status directly, but would ask questions such as:

Have you ever tested for HIV?

How would you react if you tested HIV-positive?

What will you do if you test negative and I test positive or verse versa?

Kagiso believes that HIV should be normalised just like diabetes and hypertension and awareness to be increased in his area.

Rea is 22 years old and unemployed woman. She learned about her status in 2010 when she got a rash. She has been in her current relationship for three years. When she found out about her status she was afraid to inform her partner. They went for an HIV test together and her partner tested negative. Later during the year the partner went for circumcision and he tested positive. He took the results well and did not react with hostility negatively towards Rea. He just said he would be supportive. She said it is important for one to know about their partner's status because if one finds out on one's own, it will lead to mistrust.

Neo (38) is single, unemployed and has one child. She tested HIV-positive in 2008 when she was sick. Her partner left her when the child was one year old after she told him about her status. It took a long time for him to talk to her after she had disclosed her status. She says the partner apparently went for a test and claims to have tested negative. Neo was afraid to be in relationship after learning about her status, she thought one cannot be in a relationship when they are HIV-positive. She said that she had problems disclosing her status to her new partners because she would not know where to start. However, she mentioned that she does not have a problem disclosing her status to her friends and family. Although she has difficulty disclosing her status to sex partners, she wants to inform her partners about her status before agreeing to be in a relationship with them because it helps one to enjoy the relationship more. She mentioned that after informing her daughter and friend about her status she felt relieved.

Rego is 32 years old, single, and has two children. She found out that she was HIV-positive in 2009. She was in a relationship with a married man and they had been together for four years. When she informed her partner about her status, he told her he was HIV-positive as well. She says her partner had never informed her before about his status.

Rego said the partner did not support the child for three months after her disclosure. She had to apply for maintenance and get a DNA test for him to support the child. She has been using condoms since her HIV-positive status. Rego said it is important to inform your partner about your status so that you can get support. Rego's former boyfriend wants them to start a relationship again but she doesn't know where to start because she fears being rejected again.

Lerato was a 26-year-old single woman with two children. She experienced chronic headaches in 2011 and tested for HIV. Her partner did not know about her status because he was in prison. They never used condoms. She had been with her partner for two years. She says that she has difficulties disclosing her status to him because he is stubborn and not usually an understanding person. Apparently he had two cousins who were HIV-positive and he did not treat them well. He would not eat the food they cooked. Lerato assumes that her partner knows about his positive status because when she asked him about it he just said that they would talk. She said it is important to inform your partner about your status because non-disclosure can interfere with your adherence to treatment. She said that she would inform her partner when he is released from prison. She says that it would depend on him if he wants to continue with the relationship or not. She recommended couple testing.

Kago (28) is single and has with no children. She learned about her HIV status in 2006. She said that she was scared of being in a relationship because she was raped by her two uncles when she was nine years old. The matter was never reported to the police and was never dealt with. She tried for the first time to be in a relationship when she was in Grade 11 but it was difficult for her to engage in any sexual activities. She went for an HIV test when she developed pimples that looked like chicken pox and found out that she was HIV-positive. One of the two uncles who raped her passed away and she heard rumours that he was HIV-positive. She wondered if she really got the virus from him and also wondered why it took so long to show. Kago is willing to inform her partners about her status if she gets into a relationship so that they can practise safe sex. She says that healthcare providers should continue to encourage PLWH to disclose their status to their sex partners.

Katlego (40) is a divorcee and has one child. Katlego was not aware of her HIV-positive status at the time of the divorce. She is, at the moment, cohabiting with her partner of two years. Katlego learned about her HIV status in 2002. His partner is on ARVs. Katlego and her partner are in a supportive and healthy relationship. She says that she did not experience any problems when disclosing her status to her partner. When Katlego told her partner about her status. This is how she said it:

“Next year you’ll be sitting on the mattress”.

He responded: *"You will sit on the mattress before me"*.

(Sitting on the mattress is an African cultural practice for mourning one's partner.)

Katlego and her partner do not always use condoms. She said it is important to disclose so that partners can take care of one another when sick. She encourages people to live positive lives before knowing their status. She said practising/rehearsing before disclosing gives one courage. She used to joke and told her partners that she was HIV before she really knew about her status and that helped her.

Tumelo is 41 years old and married with two children. She learned about her HIV status in 2008. When they tested together, her husband's results came back negative. He was quiet for some days after testing. After a while he became supportive and confessed that he had a relationship with a partner who passed away because of HIV. They were not using condoms before then and sometimes that caused conflict between them. They went for couple's counselling and after that they began to use condoms. She said it helps to inform your partner about your status because this makes one feel free to take their medicine.

Maki, who is 35 years old, is single, unemployed and has two children. She has been in a relationship with her partner for five years. Maki learned about her HIV status in 2007 when she experienced bleeding gums. She was raped in 2004 and had heard through rumours that the perpetrator was HIV-positive. She never reported the incident. Maki's current partner, who was furious at first, knows about her status. He left Maki for one month but later accepted her and started to support her. She often reminded her to take treatment. She said it is important to inform your partner about your status because it helps one cope with the disease. Maki recommended couple testing.

Abel (37) is unemployed and has no children. He learned about his status in 2008 when he got sick with tuberculosis. His ex-girlfriend passed away and he only learned about her HIV status after her funeral. Abel met with another girlfriend at the wellness clinic. They knew about each other's status because they were both on ARVs. He says it is important for partners to know about each other's status. Abel says he uses condoms, sometimes. He recommends that we should continue encouraging people to disclose to their partners and offer them support.

4.3 FINDINGS OF THE STUDY

Findings of the study are represented in terms of biographical data of samples, reasons for HIV testing, use of protection followed by willingness to inform one's partner about one's status, and the theme and categories, which emerged from the qualitative data.

4.3.1 Biographical data

This section describes characteristics of participants who took part in this study. Data collected includes age, gender, marital status, schooling, number of children and employment status.

Table 4.1 Biographical data of participants

Age	Number
20 –25	1
26–30	3
31–35	2
36–40	5
41–45	2
Gender	Number
Female	10
Male	3
Marital status	Number
Single	9
Customary marriage	1
Civil marriage	1
Cohabiting	2
Educational level	Number
Never attended school	0
Up to Grade 7	1
Grade 8 to 10	1
Grade 11 to 12	11
Employment status	Number
Unemployed	12
Employed	1
Number of children	Number
0	3
1 – 2	8
3 – 5	1
6 and more	0

In the present study the most represented age group (5 out of 13) was the 36 to 40 years old age group followed by the 26 to 35 years old age group represented by three participants each. The age group 41 to 45 years old was represented by two participants and the 20 to 25 years old age group by one participant.

The sample confirms what Avert (2010: 3) said that almost one in three women aged 25 to 29 are affected and more than a quarter of men aged 30 to 34 are affected in Sub-Saharan Africa. The Third South African National HIV Communication Survey (2012:1) also assert that HIV prevalence peaks among females aged 25 to 29 years at 32.7%, while for males, it peaks at 25.8% in the 30 to 34 years. This is also supported by the literature that said that generally, the population most affected globally are the 15 to 49 years old age group (UNAIDS 2010:5).

The majority of the sampled participants (9 out of 13) are single. Two are married according to civil law and customary (marriage) law and two are cohabiting. This is in contrast with the studies of Budlender, Chobokoane and Simelane (2004:5) which found that cohabitation was a real problem for most poor women. This did not seem to be the case in the present study as most female participants (10 out of 13) were unemployed but did not opt for cohabiting.

The majority of participants in the study were unemployed (12 out of 13), only 1 out of 13 was employed. Two of the participants received social grants and most were dependant on their parents.

The majority of the participants (10 out of 13) are women, most (11 out of 13) are literate, they attended school up to Grade 12 and only two of the participants had finished school with Grade 7 and Grade 8.

According to WHO (2010:86), 88% of South Africans are literate This is also supported by the study which found that the percentage of individuals with a tertiary education qualification increased from 9,2% in 2002 to 10,9% in 2009 and those with Grade 12 from 21,5% to 26,1% (GHS 2009:45). In this study, most participants had their Grade 12.

The majority of participants (8 out of 13) had two children or less, only one participant had three children and 1 out of 13 participants did not have children because of fear of being in relationships. According to WHO (2010:2), the fertility rate is at 2,5 – with children born per woman. South Africa has experience a 40% decline in fertility from pre transition. It has also emerged in the survey done by South African Institutes of Race Relation (SAIRR 2009:51) that South African women are having fewer and fewer children.

People who talked about testing with their sex partner were more likely to test for HIV (63%) than those who did not talk about testing with their partners (33%) (Third South African National HIV Communication Survey 2012:5).

4.3.2 Reason for HIV testing

The majority of the participants, 11 out of 13 participants tested because they were chronically ill, suffered from an ailment or their partner had passed on. This was supported by Lugulla, Madihi, Sigalla and Mnutu (2008:xii) in their study of social context of disclosing HIV test results done at Tanzania. The study reported that the majority of persons interviewed had been chronically ill when they were tested for HIV the first time; most of them came for testing because their spouse or sexual partner had died of symptoms similar to Aids. This shows that there are still people who wait to be sick before they can know about their HIV status.

4.3.3 Themes and categories generated from the study

Two themes and five categories emerged from the qualitative data. All these will be discussed and participants' narratives will be presented to support the findings. The themes and categories generated from the data are displayed in table 4.2.

Table 4.2 Themes and categories generated from the study

Themes	Categories
Support	<ul style="list-style-type: none"> • Partner reaction to disclosure • Partner support • Relationship with God
Sexuality	<ul style="list-style-type: none"> • Sexual behaviour • Children desire

4.3.3.1 Theme 1: Support

The first theme that emerged was support, with two categories: Partner reaction to disclosure and partner support.

Category 1: Partner reaction to disclosure

The majority of the sample (9 out of 13) had disclosed their statuses to their sex partners. Three participants had not disclosed because they were not involved in relationships and one did not disclose because he feared to be rejected. They reported a variety of partner reactions ranging from fear, ignorance, anger, secrecy, rejection, silence and acceptance as displayed in table 4.3.

Table 4.3 Partner reaction to disclosure

Partner reaction	Participant's narratives
Fear	"I feel that informing a new partner about my status will scare them away. One partner freaked after I informed her about my status and she stopped contacting me, I later told her I was joking and then she came back" (Kagiso, 28).
Ignorance	"When I told him, he just took it lightly. He would sometimes bribe me into not using a condom. The day I informed him, we did not have a condom but he insisted on having unprotected sex" (Kitso, 42).
Anger	"He was furious with me at first after I informed him about my status. He deserted me for one month but later accepted and started supporting me and reminding me to take treatment" (Maki, 35).
Secrecy	"When I told him, he said he is HIV-positive. He did not inform me before that he was HIV-positive" (Rego, 32). "We did couple testing. He remained quiet for some time after receiving the result and later he began to be supportive and confessed that he had a relationship with a partner who had died because of Aids" (Tumelo, 41).
Rejection	"He did not support the child after I informed him about my status until I applied for maintenance and took a DNA test and we are no more together" (Rego, 32). "My partner left me when the child was one year old after I informed him about my status" (Neo, 38).
Silence	"We went for couple testing, and he tested negative. He was quite after testing and later he started to be supportive and confessed that he had a relationship with a partner who died of Aids" (Tumelo, 41).
Acceptance	"When I disclose to him, I said you will be sitting on a mattress next year", and he said the same thing.

The partners' reactions varied. Two out of 13 participants were rejected after disclosing. Silence, acceptance and secrecy about the status were also experienced. This study supports the finding by (Kebede et al 2008:81; Greeff et al 2008:311), which ascertains that although positive effects of disclosure have been identified, such acceptance and support, there are also potential consequences associated with disclosure such as abandonment and discrimination.

Ignorance was also observed from this study which is supported by Louque (2010:28) which state ignorance of a sexual partner's status has also been shown as the main reason for the spread of HIV.

Category 2: Partner support

Participants (6 out of 13) received support from partners after disclosing. Although the partners initially reacted negatively to the news, they later accepted and offered their partners support.

Their narrative follows:

"He was furious with me at first. He deserted me for one month but later accepted and started to support me and even reminded me to take treatment" (Maki, 35).

"We went for couples testing, and he tested negative. He was quite afterwards but he later started to be supportive and confessed that he had a relationship with a partner who had died because of Aids" (Tumelo, 41).

The finding of the study supports the findings of Gari et al (2010:10), which has found that disclosure of HIV status to sexual partner is beneficial in that it may motivate the other partner to seek HIV counselling and testing, reduces risky behaviour and increases support and adherence to antiretroviral therapy (ART).

4.3.3.2 Theme 2: Sexuality

Sexuality is defined by HIV SA Toolkit (James & Saloner 2005:41) as a unique (individual) expression of our sexual side which is based on our values, beliefs, experiences and feelings about ourselves in relation to sex.

Three of the participants had difficulties in having sexual relationships and their narratives are as follows:

Ever since she learned about her HIV-positive status, Neo (38) has been afraid to be in relationships. “I thought when you are HIV-positive you cannot be involved in sexual relationships”.

“I tried to pursue relationships when I was in Grade 11 but it was difficult for me to engage in sexual activities because of that experience (of rape)” (Kago, 28).

Ole (39) had tried to pursue relationships after recovery but potential partners did not show any interest. “At first, they would give me promises but the next day they would suddenly change their minds. I have given up hope, but next time I will try to pursue people of the same HIV status”.

Category 1: Desire to have children

Rea (22) and his partner had a desire to have a child but wanted to know how to prevent the child from being infected. This desire was supported by Mlambo and Peltzer (2009:29-41) in their study which has found quite a number of participants who didn't know the statuses of their partners but wanted to have children with them.

4.4 CONCLUSION

Chapter 4 covered findings of the study which elaborated on history of each participant, reactions after disclosure of HIV status, themes and categories which arose from the study. There were more females than males in the study. Most females disclosed their statuses immediately after learning about their statuses as opposed to their

counterparts, who were secretive. The study showed more willingness on the side of women to disclose as compared to men. More intervention is needed in this regard.

CHAPTER 5

DISCUSSION OF THE FINDINGS

5.1 INTRODUCTION

Chapter 5 presents the summary of findings that emanated from this study.

5.2 DEMOGRAPHICS AND CHARACTERISTICS OF PARTICIPANTS

Thirteen interviewed participants were receiving their ARVs at the Galeshewe Day Hospital. Participants were between the ages of 20 and 45 years, which is supported by the literature that said generally the population most affected by HIV globally are aged between 15 and 49 years (UNAIDS 2010:5).

The majority of participants (10 out of 13) were single, unemployed women who completed their secondary school within an age group that is typically sexually active and were having children. Only one female participant cited not having a child because of fear of engaging in sexual activity. Three out of 13 were males.

5.3 DISCLOSURE TO SEXUAL PARTNERS AND SERO-DISCORDANCE

Most participants (10 out of 13) reported that they had disclosed their HIV-positive statuses to their sex partners. This finding is supported by Iwuagwu's (2009:56) study which reported all his participants to have disclosed to their husbands or partners and Seid et al (2012:100) who reported 93.1% disclosure to sexual partners. This is in agreement with the reviewed literature of most studies which reported high rate of disclosure with the lowest rate reported in the 1999 (Iwuagwu 2009:56; Seid et al 2012:100; UNAIDS 2010:5). The other three participants did not disclose because two were not involved in relationships and one participant was waiting for partner to be released from prison.

Some (4 out of 13) of the participants experienced some form of rejection by partners after disclosing their HIV status. The majority (9 out of 13), however, reported support from partners after disclosure.

Two participants reported that their sexual partners were HIV-negative; one said her sexual partners refused to test. When one partner is HIV-positive and the other is HIV negative they are said to be sero-discordant. When both are positive they are known as sero-concordant.

5.4 WILLINGNESS TO DISCLOSE

Most participants were willing to inform their partners of their statuses. This was supported by the Third South African National HIV Communication Survey (2012:5), which affirms that among those who have ever been tested, and know their statuses; 86% were willing to share their HIV status during the interview. Few participants argued that the fear of being rejected by their partners hindered them from disclosing their status. This was supported by literature from the United State Agency for International Development (USAID)/Synergy (2004) which argues that perceived negative reactions discourage people from disclosing their status.

No participant mentioned any form of discrimination which was indicated by the willingness to disclose. This is reinforced by findings of the Third South African National HIV Communication Survey (2012:5) which alluded that social stigma is gradually disappearing, which is increased by HIV communication programmes and cumulative behaviour change in South Africa over the last 10 years. Factors that the participants felt would disable their disclosure included not knowing where to start, difficult partners and fear of rejection.

Although few participants feared to disclose, they mentioned that disclosure is a difficult process. They communicated the need to disclose to protect their partners from contracting the disease so that they could live freely and positively about their conditions while supporting one another.

5.5 USE OF CONDOMS

Most participants (7 out of 13) stated to have used condoms after learning about their statuses, although not all the time. Some were not willing to use condoms even after learning about their partners' HIV statuses. This was supported by the findings of Mlambo and Pelzer (2011:36) who argued that most people in sero-concordant relationships and sero-discordant relationships try to use or are using condoms since they learned about their HIV status despite this, they also cited challenges with regard to condom use for some partners.

From the present study, it is clear that knowledge does not necessarily translate into action. Partners continued to have unprotected sex even after learning about the positive result and knowing the routes of HIV transmission.

5.6 REASON FOR TESTING

Most participants (12 out of 13) from this study learned about their status when they were sick or suffering from an ailment. This finding is supported by Shisana, Rehle, Simbayi, Parker, Zuma, Bhana, Connolly, Jooste and Pilla, (2005:83) in their recent South African study of HIV prevalence, which has shown a significant percentage of respondents who used VCT services because they were pregnant or they were sick.

Almeleh (2006:142) also in her study: *Why do people disclose their HIV status?* showed that most participants seek HIV testing because they are pregnant or sick. Lugulla et al (2008:32) also cited poor health as the main reason for HIV testing. It is evident that some communities are still not willing to voluntarily test for HIV before they get sick. Although research (Third South African National HIV Communication Survey 2012:4) reported now recently that the main reason for getting tested among sexually active people was to know their HIV statuses (76%), the remaining (34%) only go for HIV tests when they are sick.

5.7 SILENCE AND SECRECY

It has emerged from the present study that males are too secretive about their HIV statuses. They kept quiet about their statuses until the female partners tested positive – and that is the only time when they admitted that they had suspected something regarding their own statuses all along.

This was supported by Seid et al (2012:102) which also stated that silence in male partners could be either due to the reason that they are already infected. This was in agreement with the findings at Jima University Hospital in Ethiopia. It emerged from the study that couples' testing helps to facilitate disclosure (Erku, Megabiar & Wubshi 2012:860).

5.8 CONCLUSION

Chapter 5 presented the summary of findings of the study, which elaborated on the willingness of partners to disclose, use of protection, silence, secrecy and factors that prohibit disclosure to sex partners. Chapter 6 will look at recommendations, future research and limitation of this study.

CHAPTER 6

CONCLUSION, LIMITATIONS AND RECOMMENDATIONS

6.1 INTRODUCTION

Proceeding from the previously discussed chapters, this chapter bears conclusions on whether partners should disclose their HIV statuses to their sexual partners, the limitations experienced during the period of the study and the recommendations for future research.

6.2 SUMMARY

The majority of participants were willing to disclose their statuses to sexual partners despite the possibility of rejection and other contributing factors such as not knowing how to start when disclosing to one's partner. WHO (2004:6) supports these findings by stating that despite the difficulty in the beginning, disclosures increases over time.

Regardless of fear, there was a general agreement among those who participated in the study on the importance of disclosing one's HIV status to his/her sexual partner. Similar to Cloete, Strebel, Simbayi, Van Wyk, Henda and Ngeketo (2010:7)'s study, the use of condoms, particularly among men, was not adhered to because of their cultural believes and the myths surrounding the use of condoms, which it turn made it difficult for them to disclose their statuses if found positive.

In addition to this, the study revealed that fewer males made use of healthcare services as compared to females, assenting with the study of Kebede, Woldemichael, Wondafrash, Haile and Amberbir (2008:8:81), that says that gender was associated with HIV disclosure. However, according to Skogmar, Shakely, Lans, Danell, Anderson, Tshandu, Ode'n, Roberts, Francois and Venter (2006 18:725-730), in their South African study of disclosure, males disclose their result more often than females. This is in contrast with another South African study by Olley, Seedat and Stein 2004 (8:71-76) that reveals that male sex is allied with non-disclosure.

Only one participant reported stigma and discrimination as possible factors during disclosure, which is on the other hand argued to be decreasing while compared to the study of the Third South African National HIV Communication Survey (2012:5) that stated that this could be due to HIV communication programmes.

Most (70%) participants who disclosed received support from sexual partners and only a few (30%) received rejection, indicating the possibility of disclosure of HIV-positive status to sexual partners being much easier due to reduced stigma and rejection. This study also shows that ignorance still exists among HIV-positive partners who insist on having unprotected sex despite their knowledge on the statuses, however also indicate how counselling in HIV programmes can improve disclosure to sexual partners.

6.3 LIMITATIONS

As any other study this research also came across a number of limitations as follows:

- Only a limited number of males were willing to participate in the study, which in turn makes generalising difficult and not objective, testing the reliability and validity of this research.
- The study was dominated by female participants and covered mostly PLWH on ARV treatment leaving out views of those not on treatments but HIV-positive.
- The study consisted of a small sample that was dominated by females making generalising of findings almost impossible.
- The complexity of a positive status is also acknowledged as disclosure couldn't be explored within a once-off interview.

6.4 RECOMMENDATIONS

- Measures need to be put in place to empower men to talk about HIV, its impact in their lives and to engage in HIV programmes by advocating male clinics, more especially in rural areas.
- It is evident from the study that HIV counsellors do not communicate disclosure with patients in depth, which is particularly similar to Lugulla et al's (2008) study

that encouraged HIV counsellor to discuss the importance of disclosure with their patients more often and directly.

- HIV counsellors need to be capacitated on how to handle disclosure, especially to sexual partners.
- Couples' testing should be strengthened as well as mutual disclosure of HIV test result, which should be done under the guidance of HIV counsellors to support those who have difficulties disclosing to their partners.
- This is a key intrusion in increasing access to earlier ARV and reaching more men. WHO (2012:5) has emphasised that greater programmatic emphasis on partners could bring about significant reductions in HIV.
- HIV communication programmes and cumulative behaviour change need to be strengthened to reach all communities and focus more on males.
- Support groups should be implemented and developed as they have been found to assist in facilitating acceptance of HIV-positive status and disclosure to others.

6.5 CONCLUSION

The purpose of the study was to explore factors associated with the reluctance of PLWH to disclose their HIV status to their sexual partners in Galeshewe in Kimberley, Northern Cape province, South Africa. The study used qualitative research methods to gain insight into reluctance of PLWH to disclose their HIV-positive statuses to their sexual partners. In-depth interview was conducted with 13 PLWH males and females between the ages of 18 and 45.

Problems such as not knowing where to start when disclosing, ignorance about HIV-positive status, silent and secrecy were stated as factors which make participants reluctant to disclose. Positive and negative outcomes as reported by other studies were experienced by the study participants. One of the negative outcomes reported was rejection.

This study has shown an increase in percentage of disclosure and willingness to disclose for those who have not disclosed their HIV-positive status to their sexual partners. The benefits of disclosure recognised in this study were support and acceptance.

There is still a need for improvement in those who still fear to disclose because of not knowing where to start when disclosing and for some who feared rejection.

Strategies need to be put in place to assist those who have fear of disclosure.

Gender role is a key aspect in dealing with disclosure of HIV-positive statuses. Females in this study have shown great involvement in disclosure as compared to their male counterparts. Greater involvement in males is needed. Disclosure of HIV-positive status can improve if all the communities involved do their part.

If all the areas that need improvement could be strengthened maintained and everyone could take his/her responsibility, then disclosure to sexual partner would be reached and new infections (due to non-disclosure) will be reduced. In context of prevention of further new HIV infections, disclosure of HIV-positive status to sexual partner is important and needs to be enhanced.

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ANNEXURE A

Requesting permission from Chief
Executive Officer to conduct the study

ANNEXURE A

REQUEST LETTER

DATE: 30 April 2012

Dear

REQUEST FOR PERMISSION TO CONDUCT RESEARCH AT WELLNESS CLINIC

I am writing to request permission to conduct a research study at your institution. I am currently enrolled in the MPH programme at the University of South Africa, and I am in the process of writing my Master's Thesis. The study is entitled **Disclosure of HIV status by people living with HIV to their sex partners.**

I hope that the hospital administration will allow me to recruit 20 individuals, males and female between the ages 18 to 49 years from wellness clinic to participate in the intended study. Interested participants, who volunteer to participate, will be given a consent form to be signed (copy enclosed) and returned to the primary researcher at the beginning of the survey process.

If approval is granted, participants will be interviewed in a quiet setting on site. The survey will start immediately after the approval. The survey process should take no longer than an hour with one participant. The survey results will be pooled for the thesis project and individual results of this study will remain absolutely confidential and anonymous. Should this study be published, only pooled results will be documented. No costs will be incurred by either your hospital or individual participants.

Your approval to conduct this study will be greatly appreciated.

Yours faithfully

.....

Registered Nurse: Maserame Oss

Student number 4827765

ANNEXURE B

Permission granted by the Chief Executive
Officer to conduct the study

ANNEXURE B

Permission granted by the Chief Executive Officer of the Day Hospital concerned to conduct the study.

As the name of this hospital should not be known, this permission is not included in the dissertation, but is available from the supervisor of this study.

ANNEXURE C

Informed consent form

ANNEXURE C

Informed Consent Form

Title of study: Disclosure of HIV status to sexual partners by people living with HIV

Principal investigator: Maserame Oss

Institute: University Of South Africa

Introduction:

I am Maserame Oss, MPH student at UNISA doing a research on disclosure of HIV status to sexual partners by PLWH. I want to know further about reluctance of PLWH to disclose their status to sexual partners and to explore ways to increase disclosure among them. Since you are one of PLWH, I would like to invite you to join this research study.

The purpose of the study is to explore factors associated with the reluctance of PLWA to disclose their HIV status to their sex partners and explore ways to help in increasing disclosure.

The interview will take about 30 to 45 minutes of your time.

Tape recording will be used upon your approval to assist in capturing the conversation for proper analysis.

There is no risk involved in this study. The information provided by you will remain confidential. Your name and identity will also not be disclosed at any time. However the data may be seen by the Ethical Review Committee and may be published in journals, however, your identity will be kept anonymous.

There will be no incentives for the participants and participation is voluntary.

If you have any further questions you may contact Principal Investigator: Maserame Oss, MPH student at Unisa. Cell: 0836553062.

AUTHORISATION

I..... (full name) have read and understand this consent form, and I volunteer to participate in this research study. I understand that I will receive a copy of this form. I voluntarily choose to participate, but I understand that my consent does not take away any legal rights in the case of negligence or other legal fault of anyone who is involved in this study. I fully understand that I can withdraw my participation from this study at any time.

Participant's Name: -----

Signature of Person Obtaining Consent: -----

Date of interview.....

ANNEXURE D

Guiding interview schedule

ANNEXURE D

SEMI STRUCTURED INTERVIEW SCHEDULE

QUESTIONARE

1. How old are you?
2. Marital Status: Married, single, divorce, cohabiting?
3. Last schooling: Grade 11 and downwards
 - Matric
4. Employment
 - Employed?
 - Unemployed?
5. What do you do for a living?
6. For how long have you been in a relationship?
7. How many partners did you have in the last 12 months?
8. When did you learn about your HIV status?
9. Did you inform your sex partner about your status? If not what are your reasons?
10. Do you think informing sex partner of your status can benefit you and the community at large, and how?
11. How often do you use condoms?
 - Sometimes?
 - Never?
12. What can be done to assist you in disclosing your status to your sex partner?

ANNEXURE E

Ethical clearance certificate

Annexure E



**UNIVERSITY OF SOUTH AFRICA
Health Studies Higher Degrees Committee
College of Human Sciences
ETHICAL CLEARANCE CERTIFICATE**

HS HDC 60/2011

Date of meeting: 6 December 2011

Student No: 4827-765-7

Project Title: Disclosure of HIV status to sexual partners by people living with HIV.

Researcher: Maserame Victoria Oss

Degree: Masters in Public Health

Code: MPCHS94

Supervisor: Prof G B Thupayagale-Tshweneagae

Qualification: D Litt et Phil

Joint Supervisor:

DECISION OF COMMITTEE

Approved



Conditionally Approved




Prof E Potgieter

CHAIRPERSON: HEALTH STUDIES HIGHER DEGREES COMMITTEE


Prof MC Bezuidenhout

ACADEMIC CHAIRPERSON: DEPARTMENT OF HEALTH STUDIES

PLEASE QUOTE THE PROJECT NUMBER IN ALL ENQUIRES